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Building the nation's body: The contested role of abortion and family planning in post-war south Sudan

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Building the nation's body: the contested role of abortion and family planning in post-war South Sudan

Abstract

This paper offers an ethnographic analysis of public health policies and interventions targeting unwanted pregnancy (family planning and abortion) in contemporary South Sudan as part of wider 'nation-building' after war, understood as a process of collective identity formation which projects a meaningful future by redefining existing institutions and customs as national characteristics. The paper shows how the expansion of post-conflict family planning and abortion policy and services are particularly poignant sites for the enactment of reproductive identity negotiation, policing and conflict. In addition to customary norms, these processes are shaped by two powerful institutions - ethnic movements and global humanitarian actors - who tend to take opposing stances on reproductive health. Drawing on document review, observations of the media and policy environment and interviews conducted with 54 key informants between 2013 and 2015, the paper shows that during the civil war, the Sudan People's Liberation Army and Movement mobilised customary pro-natalist ideals for military gain by entreating women to amplify reproduction to replace those lost to war and rejecting family planning and abortion. International donors and the Ministry of Health have re-conceptualised such services as among other modern developments denied by war. The tensions between these competing discourses have given rise to a range of societal responses, including disagreements that erupt in legal battles, heated debate and even violence towards women and health workers. In United Nations camps established recently as parts of South Sudan have returned to war, social groups exert a form of reproductive surveillance, policing reproductive health practices and contributing to intra-communal violence when clandestine use of contraception or abortion is discovered. In a context where modern

- 24 contraceptives and abortion services are largely unfamiliar, conflict around South Sudan's nation-
25 building project is partially manifest through tensions and violence in the domain of reproduction.

26 Introduction

27 War unquestionably harms people's health and health infrastructures. Maternal mortality, one of
 28 the most important indicators of the performance of health systems, for example, is elevated during
 29 armed conflict (UNFPA, 2015). War can also accelerate social change capable of sustaining, fostering
 30 or subverting national, cultural and gender identities (Grabksa, 2014; Hammond, 2004). Such
 31 extreme circumstances put cultural systems at risk of seismic change, and reveal the implicit
 32 assumptions and contradictions underlying previously unquestioned power relations (Ginsburg &
 33 Rapp, 1995). In moments of crisis, the ways people struggle to deliver and access healthcare can be
 34 interpreted as projections of their disparate views of the nation they are struggling to construct
 35 (Baines, 2003; DiMoia, 2013; Wick, 2008). In this paper, we analyse public health policies and
 36 interventions targeting unwanted pregnancy (family planning and abortion) in contemporary South
 37 Sudan as part of wider 'nation-building' after war. We understand national-building as a process of
 38 collective identity formation which projects a meaningful future by redefining existing institutions
 39 and customs as national characteristics (von Bogdandy et al., 2005).

40 Reproduction, in particular, provides a terrain for imagining new cultural futures. Children are born
 41 into complex social arrangements through which legacies of property, positions, rights and values
 42 are negotiated over time. When mothering is viewed as women's primary social role, women are not
 43 only biological reproducers but also key cultural 'transmitters' (Yuval-Davis, 2003). Reproduction is
 44 therefore "inextricably bound up in the (re)production of culture" (Ginsburg & Rapp, 1995, 2) and
 45 integral to identity formation when cultural ideals are at the core of conflicts, as in South Sudan.

46 So as to assert this identity politically, groups in conflict tend to suppress heterogeneity to speak of
 47 their hardship in a homogeneous voice and to represent the true 'essence' of their culture (Yuval-
 48 Davis, 2003). In ethnic-based conflicts, it is common for gender identities to become hardened
 49 (Erten, 2015; Malkki, 1995; Shiffman et al., 2002) or essentialised (Grabksa, 2014). Women are
 50 transformed into boundary-makers in upholding ethnic purity, reified as the reproducers of the

ethnic group and therefore in need of protection (Yuval-Davis, 2003). Masculinities become militarised, with men enjoined to kill enemy men and defile enemy women to deliberately disrupt the ethnic purity and cultural continuity of the other group (Einhorn, 2006). Armed movements from Serbia, Rwanda, Burundi, Japan, Palestine, and Turkey to South Sudan have therefore called for women to bear babies 'for the nation' (Einhorn, 2006; Erten, 2015; Malkki, 1995; Shiffman et al., 2002).

While war exaggerates femininities and masculinities, plenty of women and men resist enacting such singular visions of their bodies (Baines, 2003). War can also empower and emancipate people.

Displacement over international borders can liberalise gender relations through encounters with global humanitarianism or host communities, as it did for South Sudanese in Kenya and Uganda (Edward, 2007; Grabksa, 2014), Burundians in Tanzania (Malkki, 1995) and Afghans in Iran (Piran, 2004). After conflicts, however, many nations seek to reassert cultural norms to impose the ethnic ideals for which a war was fought (Abramowitz & Moran, 2012; Einhorn, 2006; Mclean-Hilker, 2014). Repatriation of displaced populations therefore often involves a difficult period of reconciling cultural differences (Grabksa, 2014; Hammond, 2004). Returnee women, in particular, are often perceived as agents of social transformation that threaten established gender relations (Grabksa, 2014).

Those seeking to uphold patriarchal norms of 'the nation' during and after war thus often monitor or police women's behaviour – through the legal systems, public shaming, violence and threats of violence – to ensure that they enact their allotted roles (Baines, 2003; Einhorn, 2006). 'Reproductive control' (Moore et al., 2010) or 'reproductive coercion' (Miller & Silverman, 2010) – men's attempts to promote pregnancy in their female partners through verbal pressure and threats, contraceptives interference or sabotage, and coercion related to pregnancy continuation or termination – may help explain why intimate partner violence is often associated with reduced contraceptive uptake and abortion (Adjiwanou & N'Bouke, 2015; Coyle et al., 2015). Women's access to economic power and

cultural ideologies about what they can achieve also influence women's own willingness to limit their births (Browner, 2000). Women's susceptibility to reproductive coercion and the gendered meanings they assign to their reproductive behaviours are thus highly dependent on the local politics of reproduction (Browner, 2000; Ginsburg & Rapp, 1995).

International organisations and foreign governments, in contrast, commonly see the end of war as an opportunity for bold interventions that mark a break from a nation's chaotic past (Cometto et al., 2010; Percival et al., 2014, 1). Seemingly technical projects like funding health programmes and formulating health policy serve the ambitious goal of promoting state legitimacy and peace-building through the delivery of strong health services (Kruk et al., 2010; von Bogdandy et al., 2005). Public hospitals thus become overtly political spaces, the sites of presidential ribbon-cutting ceremonies, , protests, and even mob justice (Radio Tamazuj, 2015; South Sudan News Agency, 2014).

As studies from other post-conflict settings make clear, encounters with fertility control technologies are "not simply an issue of a technological object in isolation but rather an entire cultural package and the sets of values and aspirations associated with it" (DiMoia, 2013, 9; Erten, 2015; McGinn, 2000; Shiffman et al., 2002). Family planning, in particular, is proposed as an antidote to war, capable of empowering women to participate in peace talks and reduce fertility to ward off a demographic 'youth bulge' that contributes to future conflicts (Potts et al., 2015). Below, we examine how family planning and abortion become particularly poignant sites for the enactment of reproductive identity negotiation, policing and conflict, configuring reproduction in relation to the idea of the nation, at a time when populations are mixing, institutions reorganising, and identities shifting.

Specifically, we describe conflicting discourses about control of women's reproduction promulgated by customary institutions, the Sudan People's Liberation Army/Movement (SPLA/M) and international donors with the Ministry of Health (MoH). Following Macleod et al (2011), we understand discourses as coherent systems of meanings that support institutions, are located in

history, and produce power relations and ideological effects. We also acknowledge that people do not develop oppositional positions independent of categories in the dominant culture (Ginsburg & Rapp, 1995). While customary institutions in South Sudan uphold marriage traditions that promote many children and post-partum abstinence, the SPLA mobilise pro-natalist ideals and reject post-partum abstinence and modern family planning technologies for military gain and for nation-building after the war. Meanwhile, international donors and domestic technical officers within the Ministry of Health have re-conceptualised control of pregnancy through family planning as a legitimate and modern post-war nation-building project. We analyse how these competing discourses and associated interventions have given rise to a range of societal responses, including tensions that erupt in violence between women, men, and health workers in healthcare institutions. As parts of South Sudan have returned to war (2013-present), these tensions have come to a head in the confined spaces of United Nations (UN) camps where interventions require less negotiation with the government but war still shapes women's power. Here, what we term 'reproductive surveillance' limits women's use of accessible family planning services and leads to intra-communal violence when clandestine abortion is discovered. We conclude that, in a context where modern family planning and abortion services are largely unfamiliar, conflict around nation-building is partially manifest through violence in these domains.

Methods

Our analysis is based on ethnographic research conducted by JJP between 2013 and 2015, as part of a multi-country study of reproductive health policy change designed and led by KTS. JJP conducted critical review of policy and media documents; monitoring of social media discussions; and observations in the capital, Juba during visits to four reproductive health facilities (public and private), a UN Protection of Civilians camp, and a women's organisation network event on South Sudan's ratification of the 'Maputo' Protocol on the Rights of Women in Africa. At the time of field

work, there were more than 100,000 people living on UN bases, including 33,000 in Juba, nearly all of whom were ethnic Nuer (UNMISS, 2014).

JJP also conducted interviews with 54 key informants (in Juba and by phone) from the Ministry of Health, the Ministry of Gender, Child & Social Welfare, the South Sudan Human Rights Commission, the United Nations Population Agency (UNFPA), nurse and medical training colleges, legal organisations, domestic women's organisations, politicians, international and national non-governmental organisations (NGOs), donors, domestic and international universities, health providers, and international and national journalists. Informants likely to be able to speak about reproductive health policy were identified through web-searching, recommendations from the Ministry of Health and Juba University, and snowball sampling. Interviews followed a flexible topic guide to identify major policy debates and events, policy actors and their positions on family planning and abortion. When permitted, interviews were audio-recorded and transcribed. Documents were considered public articulations of policy actors' positions and thematically analysed together with interview transcripts and field notes which included opinions or positions circulated orally, first to identify and describe the construction of major policy discourses as they related to nation-building and second to identify and contextualise instances of policing behaviour (surveillance and sanctioning) which could suggest social tension between the discourses.

The research ethics review boards of the Ministry of Health, Republic of South Sudan and the London School of Hygiene & Tropical Medicine approved the study. All informants gave written informed consent. Because family planning and abortion policy is a highly sensitive issue, individuals' statements have been anonymised; all interviews were conducted in private with informants allowed to offer contributions without organisational attribution or being recorded.

Customary reproductive norms

South Sudanese are encouraged to have families that are as large as possible, including “as many wives as a man can afford” (Pillsbury et al., 2011, 17) and “as many children as God gives” (Aveyard & Apune, 2013, 14). The fertility rate is high, at 7.1 live births per woman (MoH-GoSS, 2013b). Large families not only provide security from high child mortality and care for adults in old age, but also lend social status (Hutchinson, 1996). Through marriage and the exchange of bride wealth, women act as bridge-builders, building alliances with other families, clans and ethnic groups (Onyango & Mott, 2011). New wives are expected to become pregnant quickly, while infertility suggests both economic and spiritual poverty (Perner, 2001). Young girls who become pregnant are encouraged to marry, since children’s well-being is the responsibility of men’s families. Almost half (45%) of South Sudanese women are married and around a quarter (28%) have delivered a live birth by their 18th birthday (MoH-GoSS & NBS, 2011). Child-spacing through breastfeeding and post-partum abstinence is common (Aveyard & Apune, 2013), facilitated by the couple living apart temporarily and/or men spending time with other women. Modern contraceptives are rarely used. Humanitarian agencies introduced condoms and contraceptive pills on a small scale in 1999 (Pillsbury et al., 2011), but by 2010, the modern contraceptive prevalence ratio was only 1.2% (4.0% for all methods (MoH-GoSS & NBS, 2011)), and only a third of women could name a modern method (McGinn et al., 2011).

In the absence of contraception, abortion is common. Constitutional law permits abortion to save a mother’s life or in the case of intra-uterine foetal death (MoLACD, 2009, sections 216-222). Many of our informants, including a parliamentarian interviewed for this study, believed that “People understand that abortion is legal when the life of the mother is at risk, they welcome this intervention even, provided it is managed by professional health workers”. Many others spoke of abortion as illegal, without nuance (see also Onyango and Mott (2011)). Although widely regarded as sinful, induced abortion also happens in all South Sudanese ethnic groups (Perner, 2001). Among the Dinka people, for example, Jok claims that women acceptably justify inducing abortion to other

women by mobilizing the concept of a 'broken back': a euphemism which acknowledges the reproductive suffering of women who have already had many pregnancies (Jok, 1999a). Among unmarried women, abortions may also be induced in secret if the woman or her family does not wish to pursue a marriage (Perner, 2001).

Women mostly self-induce abortions through methods that seek to mimic spontaneous causes, such as ingesting bitter roots or herbs, an overdose of malaria medicines, laundry detergent, battery acid or petrol; inserting objects into the cervix; or 'playing rough' (Jok, 1999a; Pillsbury et al., 2011). According to health providers, women in the capital increasingly present for post-abortion care after self-induction or receiving incomplete terminations by providers in the private health sector. Complications from unsafe abortions burden already stretched hospital services (Onyango & Mott, 2011). For example, in one tertiary facility, 45% of admissions to the gynaecological unit over a seven year period were for post-abortion care (Onyango & Mott, 2011). Although data is lacking, unsafe abortion undoubtedly contributes to South Sudan's extremely high maternal mortality, estimated to be between 730 and 2,054 maternal deaths per 100,000 live births (Kassebaum et al., 2014; SSCSE, 2007; WHO, 2014).

War & the nation's reproductive front: militarised discourses on reproduction

During and after Southern Sudan's second civil war against the Khartoum government in the Arab north (1983-2005), armed movements in the non-Arab African South mobilised pro-natalist ideals for military gain and for nation-building, which remain highly influential. Two out of the country's 12 million people are said to have died in this conflict, and the preference for many children gained urgency as people mourned their losses (Pillsbury et al., 2011). While the SPLA originated among a group of Dinka rebels defecting from the Sudan national army, over time it loosely encompassed most rebel groups from other ethnic areas of the country, thereby exposing other tribal groups to its

military culture (Schomerus & Allen, 2010). Today, the SPLA serves as South Sudan's regular army, and its 'political wing', the SPLM, is the country's governing political party, though both have splintered into multiple factions (some ethnic) since 2013.

From the late 1980s, the SPLA highlighted women's reproductive capacities as a key contribution to the war effort (Jok, 1999a, b). Soldiers were encouraged to have as many children as possible in case they died in war. The military also promulgated the concept of "brotherhood in procreation" to encourage soldiers to support each other in their quest for progeny, even from other men's wives and even through rape (Jok, 1999b, 440). Women were also urged to "hold up the reproductive front," Jok explained in a radio interview (McNeish, 2013), to contribute to future military power and to the continuity of village life and ethnic identities.

By the mid-1990s, Dinka women commonly felt the military's emphasis on reproduction as a national obligation exceeded traditional norms and lent men too much power over sexuality (Jok, 1999b). Civilian populations protested when the sexual violence which accompanied military movements crossed ethnic lines, and the SPLA, regarding these protests as a threat to its popular support, responded by publicly executing rapists (Perner, 2001). When soldiers' sexual violence occurred within ethnic communities, however, elites in both military and customary institutions were complacent because they feared allowing women to re-shape sexual norms themselves (Jok, 1999b). In a context of young men conditioned to the use of force and precarious access to health and social care for women and their children, induced abortions appeared to become an increasingly common phenomenon: a small survey, contributing one of the only estimates from this time, suggested 35% of women terminated their pregnancies (Jok, 1999a).

In the post-war period, militarised expectations of women's fertility were repurposed for Southern nation-building and recovery as the SPLM sought to distinguish itself from the north both culturally and administratively, in preparation for Independence. Around the time of the Comprehensive Peace Agreement in 2005, for example, former rebel leaders in the highest political office set about

dismantling South Sudan's only domestic family planning organisation, according to a parliamentary interviewee. This was ostensibly done under a nationalist agenda because the organisation survived on international support through Khartoum, but it was clear to observers that it was actually opposition to foreign *ideas* about reproduction that underlay the move. According to this parliamentarian, SPLM officials entreated its staff "not to talk about family planning, [but to] allow people to produce as much as they can". In the lead-up to the Independence referendum in 2011, politicians again emphasised strengthening the nation through numbers. 'Come back to be counted' was the slogan of campaigns calling refugees back to re-build and re-populate South Sudan. Being counted was a political act to strengthen political negotiations with Khartoum because census estimates would ultimately determine the South's share of oil wealth, and enabled refugees to demonstrate their citizenship in a nascent state (Hovil, 2010). In the buoyant pre-Independence atmosphere, the SPLM's ideas about building a new nation were popular. Family planning, then, was not only unnecessary, but also unpatriotic. One health provider in Juba put it quite simply: "[i]n South Sudan, the history of this war, many people have died so it sounds as if you are anti-human, not promoting life." Thus, reproduction after the war was most often spoken about as serving the new nation by replacing the high numbers of people who were lost. This was the key discourse that the Ministry of Health and its international partners sought to challenge.

Family planning to build a healthy nation: 'modern' discourses on reproduction

Given the extremely limited capacity of the new government's Ministry of Health after the war, international institutions, notably the World Bank and the World Health Organization, and international donors working through international NGOs were central drivers of health policy formulation in South Sudan (Cometto et al., 2010). In assisting the Ministry of Health to design foundational health policies and financing mechanisms, their stated priorities were to implement

interventions with the highest evidence-based impact so as to demonstrate health as a 'dividend' of peace and prevent a return to war (ibid). Ministry of Health actors, many of whom had received university training or experience abroad, claimed the adoption of international best practices served to "fast forward" the development of health services (MoH-GoSS, 2007, 1). Early policy documents included a large number of sexual and reproductive health services including family planning and post-abortion care, though not safe abortion services (Roberts et al., 2008). Like in other African countries (Storeng & Ouattara, 2014), offering post-abortion care was a politically palatable way for both domestic and international policy actors to promote the idea that they were providing 'life-saving care' without having to engage in the contentious issue of abortion rights.

The international community was highly aware of the SPLA's pro-natalist population replacement discourses. Consequently, many NGOs considered providing contraceptives a political and security risk. One NGO representative even feared that communities who rejected family planning might take-up arms against them and force programmes to close, compromising their wider maternal health and primary healthcare aims. As donors described in interviews, dispelling such fears was thus a key aim when USAID, UK Aid and the Ministry of Health commissioned a series of in-depth qualitative studies on South Sudanese attitudes and practices related to family planning which they hoped NGOs would read before designing interventions (Aveyard & Apune, 2013; Mason, 2012; Pillsbury et al., 2011).

As in many parts of Africa, these studies characterised 'family planning' as a customary cultural ideal when practiced as birth spacing through post-partum abstinence, a healthy way of life that many Southern Sudanese communities aspired to return to. More controversially, however, the studies also highlighted the local realities that made these customary practices difficult and justified introducing modern methods of contraception, such as war-related displacement to urban or camp settings with restricted living space forcing husbands and wives to share bedrooms (Aveyard & Apune, 2013; Pillsbury et al., 2011). The studies documented suspicion and stigma associated with

modern contraceptive methods and popular discourse, lumping abortion with other examples of cultural ‘pollution’ imported by returnees and foreigners after the war, such as short skirts and hip-hop culture (see also Grabksa, 2014). Like elsewhere, people commonly invoke such dichotomies between ‘modern’ and ‘customary’/‘traditional’ to make sense of competing gender ideologies (Plesset, 2006). Significantly, however, some policy actors claimed that the reports suggested communities’ sincere curiosity and openness to learning about modern health practices which could, potentially, extend to contraceptives. Other research supports this interpretation. For instance, Christian church-goers in South Sudan have sometimes been influenced by liberal Western ideas of modernity, including on reproductive health (Grabksa, 2014), and have come to see use of modern health care as an act of religiosity or patriotism: an acknowledgement of the sacrifices of war and part of the nation-building experience (Palmer et al., 2014).

The new Ministry of Health’s first Family Planning Policy, which built on the commissioned studies, appealed to such patriotism, re-framing militarised pro-natalist discourses by counting loss of reproductive health services among the casualties of war:

South Sudan has been devastated by decades of war in terms of loss of human life, massive displacement, destruction of both physical and social infrastructure, and loss of human resource development opportunities, including the loss of experienced health professionals. This, combined with a lack of awareness, has seriously limited both access to and use of quality reproductive health services including family planning (FP). As a result the country has some of the highest maternal and child mortality rates in Sub-Saharan Africa (MoH-GoSS, 2013a, p. 1,).

Like the commissioned studies, this policy document subtly sought to reposition attitudes on family planning, as a Ministry of Health representative explained: “We need to change this discourse to replace those lost with *healthy* people so that she [a woman] can look after her children and

contribute to the national economy. These are the twists and turns we need people to understand to link health and development.”

Many health workers, discussing their experience of the country’s first family planning programmes, saw the association between family planning, abortion services and modernisation as an inevitable national trajectory. One obstetrician even predicted it would be only a matter of time before family planning and abortion services are as widely available as in neighbouring countries like Ethiopia, Sudan and Kenya: “Sometimes in Kenyatta [hospital in Nairobi] you have to clean 100, even 200 pregnancies, so abortion was legalised to minimise these complications. For us, we will be heading to that, as urbanisation becomes a problem” Indeed, since 2013 especially, contraceptive coverage and method availability has expanded to include the internationally standard range of short- (condoms, pills, injections) and long-term (implants, intra-uterine devices) methods, as has access to safer medical abortion medicines (Hudgins et al., 2014).

Among the public, however, such ideas around family planning and modernity did not yet resonate. Women’s group leaders spoke animatedly about several other reproductive health issues in local political terms: gender-based violence, fistula as a problem of early marriage, and HIV as a problem of widow inheritance, all of which were worse because of war. Discussions in the Maputo Protocol workshop revealed how groups had successfully argued for protection against fistula and for a women’s right to divorce by mobilising women’s and men’s desire to uphold reproductive norms which reward large families. Just as Jok’s ‘broken back’ euphemism simultaneously valorised many pregnancies and permitted a woman to terminate one, a lawyer described the best way to win a divorce was to prove that a woman wanted to contribute children to society but had been abandoned by her husband and therefore was denied her reproductive potential. Divorce would make her a better mother. No women’s groups, however, seemed to have developed arguments for or against family planning or abortion. As one representative said, “Women’s groups might take up family planning one day, but I don’t know...”

Contesting competing discourses in post-conflict Juba

The tensions between customary, military and donor-influenced policy discourses have given rise to a range of societal responses, including tensions that erupt in legal battles, heated debate and even violence between women, men, and workers in health facilities. For example, while Ministry of Health discourses draw on ideas about liberalising women's rights set out in aspirational constitutional documents, such legal ideas have not widely influenced decisions in customary courts, which remain important because the post-conflict state lacks capacity to extend government courts into rural areas (Deng, 2013). No court rejects contraceptives as inherently illegal. However, while South Sudan's recently developed Bill of Rights states that women have the right to freedom of choice and thus do not need a man's consent to use contraceptives, in customary courts, ultimate authority typically rests with men (Bior, 2013). As one constitutional lawyer explained: "[a]ll the customs in South Sudan for the 64 tribes favour men". Since people in South Sudan "believe in lineage", a man can theoretically argue for and be granted divorce if he reports that his wife has used contraceptives without his permission because this "perverts" the natural way of building families (ibid). Contraception "victimiz[es] him" by artificially limiting the future value of the dowry he has paid for a woman. According to Ministry of Health representatives, some men have successfully sued international organisations that provided contraception to their wives in customary courts.

This legal context helps explain the ubiquitous stories family planning providers in Juba tell about their female clients being beaten by men who suspect they have been using contraception in secret. As one such provider described: "In our culture, if a woman does something secretly, he can beat her. [...] If the husband refuses and then the lady goes [to get contraception]... It will bring big problems, even if she has 5 or 10 children, he will divorce". Discussions around the choice of contraceptive method are therefore based not only on clinical considerations but also, as several antenatal care providers explained, on how well the method can be concealed, with injections, intra-

uterine devices and implants preferred. Relatedly, health workers must also be prepared to risk anger from clients' husbands:

The other day, a man came carrying a gun, demanding the implant to be removed from his wife's arm. We tried to talk to him, saying the woman came to us, she has a right. But he insisted and threatened us. So we said 'Ok, no problem, we don't want to spoil your relationship with your wife. We will remove, and she is welcome if she wants to come back another time.' The woman consented, it was just not the man.

Health providers also risk sanctions from some local government authorities who oppose family planning. One lawyer told of a health provider who was jailed for giving women contraception "in secret". At her release two days later she was forced to choose between resigning and working under the surveillance of security guards. According to international organisations, medical personnel have chased away women seeking family planning counselling at antenatal clinics in Central Equatoria State, and, in Unity State, discouraged returnees from continuing contraception they had been using for years in Khartoum, claiming a different set of laws and norms existed in South Sudan.

Such confrontations limit women's options, but also, sometimes, transform men into unlikely advocates of family planning. Providers from several family planning organisations told stories about husbands who initially threatened them becoming "very good friends" of the organisation and promoting their services to others after having the chance to discuss contraceptives in detail at the clinic. Policy actors also identified politicians who have attended family planning workshops and come back "completely converted," as one of them put it. But this is an unpredictable situation. Consequently, before providing contraception, many health workers seek to verify that a woman has her husband's consent, even going so far as to request men's phone numbers to confirm it. As one provider explained: "a midwife's first question is always, 'have you talked to your husband?'"

Abortion services engender even stronger tensions than contraception. As with secret contraceptive use, if a woman is discovered to have procured an abortion, she will often be punished; the “beating can go all the way to the health centre” to intimidate providers, claimed a representative of an international organisation. Police, routinely stationed at large hospitals to resolve disputes, may intervene in such instances but also contribute to an atmosphere in which providers admit they sometimes feel compelled to report induced abortion during the course of treatment.

This may help explain why women in cities like Juba often seek abortions and post-abortion care from private sector providers, particularly those operated by foreigners, where both government and social surveillance is less intrusive. However, people who oppose abortion occasionally force activities in the private sector into the political space of public hospitals. In 2012, an article in a prominent daily newspaper reported that a local politician abducted and unlawfully detained health workers from a private clinic he suspected of performing a “secret abortion” on his female relative, bringing them and the patient to Juba Teaching Hospital. Part of the moral authority he appealed to related to the type of place his relative had sought the abortion, rather than the abortion itself, reportedly saying: “I demanded to know why she was in a private clinic instead of a civil hospital” (Sudan Tribune, 2012). Appealing to readers’ patriotism, the implication here is that outside public hospitals, the capacity of the new state to control or safeguard women’s reproduction is critically at stake.

Tensions also abound around international NGOs’ work on reproductive health. During fieldwork, rumours circulated that the government passively aggressively refused to renew a Memorandum of Understanding required for one international family planning NGO to operate legally in the country because it suspected the organisation to provide abortions illegally. Meanwhile, it allowed a domestic family planning organisation closed by rebel leaders several years earlier to re-open. The small number of international organisations supporting post-abortion care programmes have also faced protest online (Baklinski, 2014; Dennis, 2012). Civil society bloggers have called for their

greater regulation, pointing to a profound discomfort with the uncertainty created by the presence of multiple strong, state-sanctioned discourses on reproduction. For example, in a post to a diaspora-run blog site (Dennis, 2012), the author, a concerned citizen in the capital, appears morally opposed to abortion, but ends by asking the government to resolve the ambiguities that cause people to operate in secret:

After 21 years of civil war in Sudan where millions of lives were lost, we would imagine that the most logical programme for the world's youngest nation—South Sudan, would be one that promotes population growth to replace the lost lives. ... Abortion is illegal in South Sudan and any organization or individual promoting abortion is promoting an illegality ... it is a bloody and murderous affair ... The big and urgent question is: for how long will this carnage continue? Or if it's the best thing to have ever happened for our girls and women, then let the government openly announce that they want to, or have already, legalize abortion ... South Sudanese must know because their love ones are dying under mysterious circumstances, all under the nose of a seemingly dysfunctional government in Juba and beyond the reach of the law! [sic]

The author implies that the ruling SPLM has lost much of its legitimacy as parts of South Sudan have slid back into internal ethnic conflict in the last two years. Within this context, nationalist rhetoric seems less enchanting. A domestic policy analyst claimed that, increasingly, people are dismissing the population replacement discourse as SPLA propaganda, particularly ethnic groups from the southern Equatorial states not directly involved in the current crisis. The crisis has also provided political space for some politicians to justify the Ministry of Health/donor discourse, as illustrated by the question one parliamentarian poses in his efforts to lobby support for family planning organisations privately with other politicians and local authorities: “if leaders are not taking

responsibility for the bad behaviours of their constituents who are keeping the country at war, how can they be expected to promote healthy behaviours like family planning?"

Sanctuary & surveillance in Protection of Civilians camps

The ethnic character of today's conflict has amplified reproductive surveillance of displaced women and the importance of population replacement to some ethnic rebel movements. Simultaneously, crisis-response NGOs have accelerated family planning interventions in UN Protection of Civilians camps, a type of uniquely protected humanitarian space requiring little negotiation with domestic governments. Here, tensions between competing discourses and practices have come to a head.

Relatively early on in the current crisis, international NGOs began offering short-term methods of contraception to populations living in UN camps, giving women who previously had to visit tertiary health facilities or private pharmacies to access such commodities easy and free access. Accordingly, women elders in one camp said they were counselling younger women to treat this situation of extraordinary access as a learning opportunity, saying "before going back to the village, we want to know how to use this medicine safely". Camp statistics so far, however, indicate relatively low uptake. For example, clinic staff at one camp visited in Juba in 2014 reported between 0 and 11 family planning service users per month for a population of around 13,000 people.

Stories from the camp suggest a number of possible explanations for such low uptake. Nuer women who have sought refuge in UN camps in Juba fled ethnically-motivated violence, including sexual violence (CARE, 2014). A year on, Nuer people still feared leaving camps and felt widely persecuted and suspicious of activities that could be associated with the Dinka-dominated state, including international organisations who must cooperate with the state to operate. For example, encamped communities turned away food aid suspected to be poisoned (Migiro, 2015) and some people refused vaccines during a WHO-led cholera campaign, citing distrust of the agencies involved (Peprah et al., 2016). In this context of conspiracy and fear, international organisation

representatives recalled that the introduction of family planning commodities into camp health services were protested as another attack on the well-being of the Nuer community; residents even successfully lobbied to have one organisation pushed out of the camp for this reason.

Health workers reported that population replacement rhetoric had also re-emerged in camp discourses, with comments such as “we need to make more Nuer fighters” shared by some men at meetings and on social media. On the other hand, an older women’s group leader explained that women feared pregnancy in the poor camp conditions and considered pregnancy as “something for the future”. This, however, did not translate into popular recognition of a need for modern family planning or abortion. Both remained greatly stigmatised, conceptualised as services required only by women who were having extra-marital affairs. Young women whose husbands were away fighting were the target of roving information campaigns, but could not legitimately use them, she claimed, or people would say, “why do you need it, you are taking it [contraception] for whom?”.

Inter-clan conflicts also erupted in camps when pregnancy evoked suspicions of adultery or when women were discovered to have induced abortions. Referring to one widely known incident, another women’s leader showed photos she had taken of a foetus retrieved from a communal latrine. She claimed that the woman procured an abortifacient outside the camp, induced the abortion in her tent and then was obliged to dispose of the foetus in the latrine. The woman’s husband was absent and neighbours had severely beaten her upon discovery for both the abortion and the assumed adultery. International organisations have reported similar events in other UN camps populated by Nuer and other ethnic groups (Radio Tamazuj, 2014). Thus, as one NGO representative explained, in the tense confines of camps, there was a need for post-abortion care - “a lot, by international standards” - both to deal with unsafe abortions and the collateral social effects. In the close confines of camp life, women’s use of state- and NGO-sanctioned contraception and abortion services is met by neighbours’ surveillance and sanctioning on behalf of the ethnic

group when husbands are away fighting. Where ideologies are being violently negotiated, such services are thus unintentionally inviting violence onto users.

Conclusion

South Sudan is in dramatic flux as new national, ethnic, gender and personal identities are being forged. Recovery from war necessitates reconciling cultural differences accrued through processes of militarisation, displacement into neighbouring cultures and exposure to globalism and humanitarianism (Grabksa, 2014; Hammond, 2004). The post-conflict context thus provides a valuable window into many contested cultural and political domains, including reproductive health, and the way in which the expansion of social policy and services becomes an integral part of peace- and nation-building efforts.

Our analysis shows that reproductive health discourses have been actively shaped by rapidly evolving institutions in ways that appeal to South Sudanese peoples' aspirations to live in a country of their own making. The competing nature of these discourses demonstrate the incoherence of South Sudan's current nation-building project: the State in effect has incomplete control of the nation(s) within its borders and this larger cultural battle between customary, militarised and modernised ideologies is expressed as contestation and even violence.

Humanitarian organisations have recently been criticised for neglecting to integrate family planning and abortion services in crisis responses due to political and donor sensitivities; insufficient understanding of abortion legality; a tendency to see the services as a 'development' rather than 'emergency' need; and a perception that the services are complicated to provide or that they are not needed (Casey & McGinn, 2016; Tanabe et al., 2015). Here, we have shown that an additional reason is NGO workers' perception that family planning and abortion services are not wanted by the population and even constitute a security and political risk to organisations and their ability to provide other priority interventions.

Sexual violence can provide a 'comfortable' justification with which humanitarian organisations can provide abortion services in crises (Casey & McGinn, 2016). Our observations in UN camps support this idea: international organisations have begun justifying the need for abortion in relation to rape (Radio Tamazuj, 2014), but they have been publicly silent on the potential that pregnancy prevention or abortion may be associated with consensual sex. Reproductive surveillance in displaced person camps, which we understand as a form of reproductive control, has also been under-appreciated here and, potentially, globally (see, for example, omissions in Hudson (2016)).

Given that health workers deal directly with patients in distress, health facilities may be particularly 'permeable' spaces where the effects of violence experienced in wider society are easily felt (di Martino, 2002). Our analysis is one of few to show that gender-based violence and violence towards health workers can be a potential *outcome* of family planning and abortion services, especially when used clandestinely (see also Bawah et al. (1999)). Additionally, we have shown how intra-communal violence can be an unintended outcome of these services in contexts of post-conflict nation-building.

The conceptualisation of reproductive health services as a risk to cultural systems is not unique to post-conflict settings, but is especially clear in South Sudan where there has been so little exposure to modern health services. Men's sometimes violent resistance to modern contraceptives reflects not only patriarchal attitudes, but also their view of such technologies as foreign and therefore threatening to South Sudanese identity. Kurds, as minorities in Turkey, are similarly resistant to government-advocated family planning and caesarean-section deliveries because they are seen as technologies of cultural assimilation (Erten, 2015). In clinical settings, supporting women to use contraception or undergo abortion in secret may be an appropriate individual-level harm-reduction approach to violence from male partners (Miller & Silverman, 2010; Moore et al., 2010). Such clandestine behaviour may appear as capitulation to the dominant ideology behind customary and military discourses. Alternatively, it can also be seen as an act of resistance or resilience pursued by relatively powerless individuals; an unavoidable necessity when resolution of competing discourses in the near term is unlikely (Grabksa, 2014; Wirtz et al., 2014).

In complex post-conflict settings like South Sudan, policy and interventions related to family planning and abortion thus invite contestation, resistance and even violence. Understanding the political, social and historical discrepancies and tensions between competing discourses is essential to understanding behaviour and the uptake (or lack thereof) of new policies and programmes. Further research should examine women's reactions to policy change, the cultural, structural and other reasons why women use services (or not), as well as the sustainability of donor-funded initiatives to increase family planning in light of their current tensions with cultural ideals. Women's groups, in particular, should be involved in making sense of nation-building discourses, to shape both the construction of problems related to women's reproduction and their solutions. State and NGO actors should work with women to meet safety, accessibility and dignity standards in delivering abortion and family planning programmes. They should also collaborate with social protection initiatives to mitigate and respond to interpersonal and communal violence against women in real time (Global Protection Cluster, 2014). While reproductive surveillance, control and violence may be expected during war, its roots transcend war and peace (Scheper-Hughes & Bourgois, 2004) and so should be anticipated during peace-building processes, too.

References

- Abramowitz, S., & Moran, M. (2012). International human rights, gender-based violence, and discourses of abuse in post-conflict Liberia: a problem of 'culture?'. *African Studies Review*, 55, 119-146.
- Adjiwanou, V., & N'Bouke, A. (2015). Exploring the paradox of intimate partner violence and increased contraceptive use in sub-Saharan Africa. *Studies in Family Planning*, 46, 127-142.
- Aveyard, R., & Apune, J. (2013). Understanding knowledge, attitudes, beliefs, and practices around reproductive, maternal, neonatal, and child health in South Sudan. BBC Media Action.
- Baines, E. (2003). Body politics and the Rwandan crisis. *Third World Quarterly*, 24, 479-493.
- Baklinski, P. (2014). African priest begs help to end 15 years of illegal chemical abortions ravaging his nation. <http://www.lifesitenews.com/news/african-priest-begs-help-to-end-15-years-of-illegal-chemical-abortions-rava> (accessed 9/9/2014).
- Bawah, A., Akweongo, P., Simmons, R., & Phillips, J. (1999). Women's fears and men's anxieties: the impact of family planning on gender relations in northern Ghana. *Studies in Family Planning*, 30, 54-66.
- Bior, A. (2013). Gender equality in South Sudan: a review of customs and constitution. The Sudd Institute. https://www.suddinstitute.org/assets/Publications/572b7eb5ad6d4_GenderEqualityInSouthSudanAReviewOf_Full.pdf (accessed 8/9/2016).

- Browner, C. (2000). Situating women's reproductive activities. *American Anthropologist*, 102, 773-788.
- CARE (2014). The girl has no rights: gender-based violence in South Sudan. CARE International. <http://insights.careinternational.org.uk/publications/the-girl-has-no-rights-gender-based-violence-in-south-sudan> (accessed 8/9/2016).
- Casey, S.E., & McGinn, T. (2016). Why don't humanitarian organizations provide safe abortion services? *Conflict & Health*, 10.
- Cometto, G., Fritsche, G., & Sondorp, E. (2010). Health sector recovery in early post-conflict environments: experience from southern Sudan. *Disasters*, 34, 885-909.
- Coyle, C., Shuping, M., Speckhard, A., & Brightup, J. (2015). The relationship of abortion and violence against women: violence prevention strategies and research needs. *Issues Law Med*, 30, 111-127.
- Deng, D. (2013). Rights, responsibilities and the rule of law. *My mother will not come to Juba: South Sudanese debate the makings of the constitution*. London: Rift Valley Institute.
- Dennis (2012). Marie Stopes International—South Sudan abortion clinic in Juba. <http://www.borglobe.com/25.html?m7:post=marie-stopes-internationalsouth-sudan-abortion-clinic-in-juba&i1742332:page=2> ; <http://paanluelwel.com/2012/01/27/marie-stopes-international-south-sudan-abortion-clinic-in-juba/> (accessed 18/11/2015).
- di Martino, V. (2002). Workplace violence in the health sector: Country case studies synthesis report. ILO, ICN, WHO & PSI joint programme. http://who.int/violence_injury_prevention/violence/activities/workplace/WVsynthesisreport.pdf?ua=1 (accessed 8/9/2016).
- DiMoia, J. (2013). Family planning and nation building in South Korea, 1961 through the mid-1970s. *Reconstructing bodies: biomedicine, health, and nation-building in South Korea since 1945*. Stanford: Stanford University Press.
- Edward, J. (2007). *Sudanese women refugees: transformations and future imaginings*. New York: Palgrave Macmillan.
- Einhorn, B. (2006). Insiders and outsiders: within and beyond the gendered nation. In K. Davis, M. Evans, & J. Lorber (Eds.), *Handbook of gender and women's studies*. London: Sage Publications.
- Erten, H. (2015). 'No more than two with caesarean': the C-section at the intersection of pronatalism and ethnicity in Turkey. *Anthropology in Action*, 22, 7-16.
- Ginsburg, F., & Rapp, R. (1995). Introduction: conceiving the new world order *Conceiving the New World Order: the global politics of reproduction*. Berkeley: University of California Press.
- Global Protection Cluster (2014). Protection mainstreaming training package. http://www.globalprotectioncluster.org/assets/files/aors/protection_mainstreaming/PM_training/1_GPC_Protection_Mainstreaming_Training_Package_FULL_November_2014.pdf (accessed 8/9/2016).
- Grabksa, K. (2014). *Gender, home & identity: Nuer repatriation to Southern Sudan*. Woodbridge: James Currey.
- Hammond, L. (2004). *This place will become home: refugee repatriation to Ethiopia*. Ithica: Cornell University Press.
- Hovil, L. (2010). Hoping for peace, afraid of war: the dilemmas of repatriation and belonging on the borders of Uganda and South Sudan. United Nations High Commissioner for Refugees. <http://www.unhcr.org/uk/research/working/4cf5018b1/hoping-peace-afraid-war-dilemmas-repatriation-belonging-borders-uganda.html> (accessed 8/9/2016).
- Hudgins, A., Egharevba, M., & Tekie, M. (2014). South Sudan maternal health and family planning commodity requirements and financing need, 2014–2016. USAID Deliver Project & UNFPA. http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/SS_RHCommQuan.pdf

- Hudson, V. (2016). Gender lenses and refugee assistance.
<https://www.opendemocracy.net/5050/valerie-hudson/gender-lenses-and-refugee-assistance> (accessed 11/2/2016).
- Hutchinson, S. (1996). *Nuer dilemmas: coping with money, war and the state* London: University of California Press.
- Jok, M. (1999a). Militarism, gender and reproductive suffering: the case of abortion in western Dinka. *Africa: Journal of the International African Institute*, 69, 194-212.
- Jok, M. (1999b). Militarization and Gender Violence in South Sudan. *Journal of Asian & African Studies*, 34, 427-442.
- Kassebaum, N.J., Bertozzi-Villa, A., Coggeshall, M.S., Shackelford, K.A., Steiner, C., Heuton, K.R., et al. (2014). Global, regional, and national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*, 384, 980-1004.
- Kruk, M., Freedman, L., Anglin, G., & Waldman, R. (2010). Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda. *Soc Sci Med*, 70, 89-97.
- Macleod, C., Sigcau, N., & Luwaca, P. (2011). Culture as a discursive resource opposing legal abortion. *Critical Public Health*, 21, 237-245.
- Malkki, L. (1995). *Purity and exile: violence, memory and national cosmology among Hutu refugees in Tanzania*. Chicago: University of Chicago Press.
- Mason, T. (2012). Family planning knowledge, attitudes, practice, and positive deviance in Western Equatoria State, South Sudan: qualitative baseline study, March 2012. Marie Stopes International, South Sudan.
- McGinn, T. (2000). Reproductive health of war-affected populations: what do we know? *Int Fam Plan Perspect*, 26, 174-180.
- McGinn, T., Austin, J., Anfinson, K., Amsalu, R., Casey, S.E., Fadulalmula, S.I., et al. (2011). Family planning in conflict: results of cross-sectional baseline surveys in three African countries. *Confl Health*, 5, 11.
- McClean-Hilker, L. (2014). Navigating adolescence and young adulthood in Rwanda during and after genocide: intersections of ethnicity, gender and age. *Children's Geographies*, 12, 354-368.
- McNeish, H. (2013). Family planning in South Sudan. BBC.
<http://www.bbc.co.uk/programmes/p013vk9f>
- Migiro, K. (2015). Uprooted South Sudanese fear the call to return home. Thompson Reuters Foundation.
<http://ca.reuters.com/article/topNews/idCAKBN0LH1HZ20150213?pageNumber=1&virtualBrandChannel=0&sp=true> (accessed 08/04/2015).
- Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Rev Obstet Gynecol*, 5, 511-515.
- MoH-GoSS (2007). Southern Sudan maternal, neonatal and reproductive health strategy action plan 2008 – 2011. Ministry of Health, Government of South Sudan.
- MoH-GoSS (2013a). Family planning policy. Ministry of Health, Government of the Republic of South Sudan.
- MoH-GoSS (2013b). The reproductive health policy: present and future prosperity through safe motherhood and healthy childhood. Ministry of Health, Government of the Republic of South Sudan
- MoH-GoSS, & NBS (2011). The Republic of South Sudan: The household health survey 2010. Ministry of Health & National Bureau of Statistics, Government of South Sudan.
- MoLACD (2009). Penal Code Act 2008, South Sudan. Ministry of Legal Affairs and Constitutional Development, Government of South Sudan. http://www.goss-online.org/magnoliaPublic/en/Laws--Legislation--Policies/mainColumnParagraphs/0/content_files/file12/15.pdf

- Moore, A., Frohwirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Soc Sci Med*, 70, 1737-1744.
- Onyango, M., & Mott, S. (2011). The nexus between bridewealth, family curse, and spontaneous abortion among Southern Sudanese women. *Journal of Nursing Scholarship*, 43.
- Palmer, J., Kelly, A., Surur, E., Checchi, F., & Jones, C. (2014). Changing landscapes, changing practice: Negotiating access to sleeping sickness services in a post-conflict society. *Soc Sci Med*, 120, 396-404.
- Peprah, D., Palmer, J.J., Rubin, G., Abubakar, A., Martin, S., & Larson, H. (2016). Perceptions of oral cholera vaccine and reasons for full, partial and non-acceptance during a humanitarian crisis in South Sudan. *Vaccine*, 34, 3823-3827.
- Percival, V., Richards, E., Maclean, T., & Theobald, S. (2014). Health systems and gender in post-conflict contexts: building back better? *Confl Health*, 8.
- Perner, C. (2001). 'But you know? Darkness is a big thing?': A background report on family attitudes and sexual behaviour in the southern Sudan as a basis for HIV/AIDS awareness. UNICEF / Operation Lifeline Sudan.
- Pillsbury, B., Stolba, A., & Hooks, C. (2011). Child spacing and family planning in South Sudan: Knowledge, attitudes, practices and unmet need. USAID.
http://ghpro.dexonline.com/sites/default/files/resources/legacy/sites/default/files/South%20Sudan%20Child%20Spacing%20%26%20Family%20Planning-Main%20Report_508%20%28secured%29_3-6-12.pdf (accessed 8/9/2016).
- Piran, P. (2004). Effects of social interaction between Afghan refugees and Iranians on reproductive health attitudes. *Disasters*, 28, 283-293.
- Plesset, S. (2006). *Sheltering women: negotiating gender and violence in northern Italy*. Stanford: Stanford University Press.
- Potts, M., Mahmood, A., & Graves, A. (2015). The pill is mightier than the sword. *Int J Health Policy Manag*, 4, 507-510.
- Radio Tamazuj (2014). Concern of widespread abortion in 'protection' camps in South Sudan. Radio Tamazuj. <https://radiotamazuj.org/en/article/concern-widespread-abortion-%E2%80%98protection%E2%80%99-camps-south-sudan> (accessed 14/04/2014).
- Radio Tamazuj (2015). Protest in Juba; 2 journalists detained. Radio Tamazuj. <https://radiotamazuj.org/en/article/protest-juba-2-journalists-detained> (accessed 8/9/2016).
- Roberts, B., Guy, S., Sondorp, E., & Lee-Jones, L. (2008). A basic package of health services for post-conflict countries: implications for sexual and reproductive health services. *Reproductive Health Matters*, 16, 57-64.
- Scheper-Hughes, N., & Bourgois, P. (2004). Introduction: Making sense of violence. *Violence in war and peace: an anthology* (p. 4). Malden, MA: Blackwell.
- Schomerus, M., & Allen, T. (2010). Southern Sudan at odds with itself: Dynamics of conflict and predicaments of peace. London School of Economics, Development Studies Institute.
- Shiffman, J., Skrabalo, M., & Subotic, J. (2002). Reproductive rights and the state in Serbia and Croatia. *Soc Sci Med*, 54, 625-642.
- South Sudan News Agency (2014). Source: Headless Bodies Turn up in Juba Teaching Hospital's Morgue. South Sudan News Agency.
<http://www.southsudannewsagency.com/news/breaking-news/headless-bodies-turn-up-in-juba-teaching-hospital> (accessed 07/04/2015).
- SSCCSE (2007). Southern Sudan household health survey (SHHS) 2006 report. Southern Sudan Commission for Census, Statistics and Evaluation. <http://ssccse.org/surveys/> (accessed 7 March 2011).
- Storeng, K.T., & Ouattara, F. (2014). The politics of unsafe abortion in Burkina Faso: the interface of local norms and global public health practice. *Glob Public Health*, 9, 946-959.

- Sudan Tribune (2012). Juba city council boss accused of kidnap, illegal detention. Sudan Tribune. <http://www.sudantribune.com/spip.php?article41540> (accessed 07/04/2015).
- Tanabe, M., Schaus, K., Rastogi, S., Krause, S., & Patel, P. (2015). Tracking humanitarian funding for reproductive health: a systematic analysis of health and protection proposals from 2002-2013. *Conflict & Health*, 9, S2.
- UNFPA (2015). Maternal mortality in humanitarian crises and in fragile settings. Population and Development Branch, United Nations Population Fund. <http://www.unfpa.org/resources/maternal-mortality-humanitarian-crisis-and-fragile-settings> (accessed 19/11/2015).
- UNMISS (2014). UNMISS PoC Update No. 55. UN Mission in South Sudan. <http://reliefweb.int/report/south-sudan/unmiss-poc-update-no-55> (accessed 22/06/2014).
- von Bogdandy, A., Häußler, H., Hanschmann, F., & Utz, R. (2005). State-building, nation-building, and constitutional politics in post-conflict situations: conceptual clarifications and an appraisal of different approaches. *Max Planck Yearbook of United Nations Law*, 9, 579-613.
- WHO (2014). Maternal mortality in 1990-2013: South Sudan. Maternal Mortality Estimation Inter-Agency Group. http://www.who.int/gho/maternal_health/countries/ssd.pdf?ua=1
- Wick, L. (2008). Building the infrastructure, modeling the nation: the case of birth in Palestine. *Culture, Medicine, and Psychiatry*, 32, 328-357.
- Wirtz, A.L., Pham, K., Glass, N., Loochkartt, S., Kidane, T., Cuspoca, D., et al. (2014). Gender-based violence in conflict and displacement: qualitative findings from displaced women in Colombia. *Confl Health*, 8, 10.
- Yuval-Davis, N. (2003). Gender and nation. *Ethnic & Racial Studies*, 16, 621-632.

Research highlights

- In post-conflict South Sudan, institutions are reorganising, identities shifting
- Humanitarian family planning discourses clash with customary and military ideals
- Peace-building, which includes family planning, leads to unexpected gender violence
- Social groups are policing reproductive decision-making in displaced person camps